

**Margaret L.Coats, Counseling Inc.**  
**Authorization for Release/ Exchange of Information**

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Information Release/ Exchange From: Facility: Margaret L. Coats, Cslg, Inc. Address: 6525 Constitution Drive Fort Wayne, IN 46804 Phone: 260-459-0990	Information Release/ Exchange to: Facility/Person: _____ Address: _____ Phone :(____) _____
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- |   |   |
|---|---|
| <input type="checkbox"/> Intake Education<br><input type="checkbox"/> Assessment/diagnosis<br><input type="checkbox"/> Compliance<br><input type="checkbox"/> Medical Records<br><input type="checkbox"/> Treatment Recommendations<br><input type="checkbox"/> Attendance<br><input type="checkbox"/> Treatment Plan<br><input type="checkbox"/> Recommendations | <input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Progress Reports<br><input type="checkbox"/> Medical Tests<br><input type="checkbox"/> Psychological Evaluation<br><input type="checkbox"/> Psychiatric Evaluation<br><input type="checkbox"/> Treatment Prognosis<br><input type="checkbox"/> Discharge summary; prognosis<br><input type="checkbox"/> Other (specify) _____ |
|---|---|

Purpose or need for such Release/ Exchange of Information: \_\_\_\_\_

Authorization to Release/Exchange Information:  
I understand that this authorization shall remain in effect for 180 days from the date of my signature below, unless an earlier expiration date is specified in this space ( \_\_\_\_\_ ). I also understand that except to the extent that action has already been taken based upon this authorization, I may revoke this consent at any time by written notification to this agency.

I hereby authorize the release and /or exchange of the above identifying information from my records. I hereby release Margaret L. Coats, Counseling, Inc. from all legal responsibility or liability that may arise from this authorization.

\_\_\_\_\_  
Authorizing Person Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Witness/Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This information has been disclosed to you from the records protected by Federal Confidentiality Rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of this person to whom it pertains or as other wise permitted by 42CFR, part 2. A general authorization is not sufficient for this purpose. The federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug consumer.